Conference Engrossed

State of Arizona
House of Representatives
Forty-fifth Legislature
First Regular Session
2001

CHAPTER 328

HOUSE BILL 2117

AN ACT

AMENDING SECTIONS 20-120, 20-629, 20-1069, 20-1069.01, 20-1072, 20-1074 AND 20-1379, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE SERVICES ORGANIZATIONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-120, Arizona Revised Statutes, is amended to read:

20-120. Payment bonds for third party intermediary entities; contract provisions; definitions

A. A health care insurer shall not contract with a third party intermediary entity for the delivery or provision of health benefits or services by or through that entity to a group or panel of covered persons, unless the third party intermediary entity at its own expense secures a payment bond or posts a cash deposit pursuant to this section.

B. The following apply to a payment bond required by this section:

1. The payment bond shall be in a face amount that is at least equal to twice the average monthly payment amount that the third party intermediary entity is entitled to receive under the terms of its contract with the health care insurer.

2. The payment bond shall be executed by a surety company or companies holding a certificate of authority to transact surety business in this state issued by the director pursuant to chapter 2, article 1 of this title.

3. The payment bond serves solely as a source of payment of claims for covered health benefits or services provided by subcontracted health care professionals to the group or panel of covered persons under the contract between the third party intermediary entity and the health care insurer.

4. A subcontracted health care professional who has provided covered health care benefits or services to one or more covered persons under a subcontract with a third party intermediary entity, and who has not been paid in full for the covered benefits or services provided pursuant to the subcontract within ninety days after the date on which the last of the benefits or services were provided, may sue on the payment bond for the unpaid amount owed under the subcontract, may prosecute the action to final judgment and may execute on the judgment against the payment bond. The suit shall commence within one year after the date on which the last of the benefits or services sued for were provided.

5. A health care insurer that pays claims of subcontracted health care professionals for covered health care benefits or services that were the contractual responsibility of a third party intermediary entity may sue on the payment bond for the claims amounts paid, may prosecute the action to final judgment and may execute on the judgment against the payment bond. The suit shall commence within one year after the date on which the last of the claims sued for were paid.

6. The payment bond shall include a provision allowing the prevailing party in a suit on the bond to recover as a part of the judgment a reasonable attorney fee as determined by the court.

7. A health care insurer shall review annually a payment bond secured pursuant to this section to determine whether the face amount of the payment bond needs to be adjusted.

C. The following apply to cash deposits required by this section:

1. A cash deposit posted pursuant to this section shall be in a face amount that is at least equal to twice the average monthly payment amount that the third party intermediary entity is entitled to receive under the terms of its contract with the health care insurer and shall be deposited with and held in trust by the state treasurer.

2. Instead of requiring a third party intermediary to post the entire cash deposit at the outset, for a six month period beginning with the initial contract payment, the health care insurer may withhold from the monthly contract payment to be made to the third party intermediary entity an amount that is equal to one-sixth of the cash deposit required to be posted pursuant to this subsection. The health care insurer shall transfer the monies withheld pursuant to this subsection for deposit with the state treasurer to be held in trust as provided in this section. Monies withheld and not yet deposited with the state treasurer pursuant to this subsection are held in trust for the purposes described in this section and are not the monies of the health care insurer.

3. A cash deposit made pursuant to this section serves solely as a source of payment of claims for covered health benefits or services provided by subcontracted health care professionals to the group or panel of covered persons under the contract between the third party intermediary entity and the health care insurer.

4. A subcontracted health care professional who has provided covered health care benefits or services to one or more covered persons under a subcontract with a third party intermediary entity and who has not been paid in full for the provided benefits or services pursuant to the subcontract within ninety days after the date on which the last of the benefits or services were provided, may sue on the cash deposit for the unpaid amount owed under the subcontract, may prosecute the action to final judgment and may execute on the judgment against the cash deposit. The suit shall commence within one year after the date on which the last of the benefits or services sued for were provided.

5. A health care insurer that pays claims of subcontracted health care professionals for covered health care benefits or services that were the contractual responsibility of a third party intermediary entity may sue on the cash deposit for the claims amounts paid, may prosecute the action to final judgment and may execute on the judgment against the cash deposit. The suit shall not commence before one year after the date on which the last of the claims sued for were paid.

6. Out of monies held on deposit by the state treasurer for a specific third party intermediary entity pursuant to this section, monies may be awarded and paid to the prevailing party in a suit on the cash deposit. The court may award as a part of the judgment on that cash deposit a reasonable attorney fee as determined by the court.

7. A health care insurer shall review annually a cash deposit posted pursuant to this section to determine whether the face amount needs to be adjusted.

D. The following apply to contracts between a third party intermediary entity and a health care insurer:

1. The contract shall require the third party intermediary entity to submit a quarterly report on the timeliness of payments made to all subcontracted health care professionals to the health care insurer to measure compliance with payment timeliness standards.

2. The contract shall require the third party intermediary entity to pay its subcontracted health care professionals within the time period specified under section 20-3102.

E. This section does not:

1. Authorize any entity that does not hold a certificate of authority to engage in the business of insurance in this state.

2. Require a third party intermediary entity to post a payment bond or cash deposit if the entity holds a certificate of authority as an administrator, disability insurer, service corporation or health care services organization.

3. Create any new private right or cause of action for or on behalf of any person, other than a right to sue on a payment bond or cash deposit under subsection B or C of this section. A general creditor or judgment creditor or any other claimant of a third party intermediary entity shall not levy on any payment bond or cash deposit secured or held pursuant to this section.

4. Require a third party intermediary entity that serves as a provider network for an affiliated staff or group model health care services organization under a common line of ownership or control to post a payment bond or cash deposit to that health care services organization. Notwithstanding that a payment bond or cash deposit is not required under this paragraph, the health care services organization may require the third party intermediary entity to meet other payment bond or cash deposit requirements established by the health care services organization. If the health care services organization does not require the third party intermediary entity to post a payment bond or cash deposit, the health care services organization is responsible for payment of claims for covered health benefits or services that are provided by subcontracted health care professionals to covered persons if the third party intermediary entity fails to make payment pursuant to the subcontracts.

5. Require one or more persons who are licensed health care professionals, hospitals or other institutional health care providers to post a payment bond or cash deposit under a contract where the assumption of business risk is limited to benefits or services that may be lawfully furnished within the lawful scope of practice by that person or persons.

6. Limit the ability of a health care insurer to impose additional financial requirements on a third party intermediary entity.

7. REQUIRE A THIRD PARTY INTERMEDIARY ENTITY TO POST A PAYMENT BOND OR CASH DEPOSIT IF THE ENTITY EITHER:

(a) HAS NOT BEEN DELEGATED RESPONSIBILITY TO PROCESS AND PAY THE CLAIMS OF THE HEALTH CARE PROVIDERS FOR WHICH THE ENTITY HAS ASSUMED THE BUSINESS RISK.

(b) HAS BEEN DELEGATED RESPONSIBILITY TO PROCESS AND PAY THE CLAIMS OF THOSE HEALTH CARE PROVIDERS WHO HAVE A WRITTEN CONTRACT WITH THE ENTITY THAT CONTAINS A PROVISION BY WHICH THE PROVIDERS AGREE TO HOLD THE APPLICABLE DISABILITY INSURER, SERVICE CORPORATION OR HEALTH CARE SERVICES ORGANIZATION, THEIR ENROLLEES, INSUREDS OR SUBSCRIBERS HARMLESS FROM HAVING TO PAY THE CLAIMS OF SUCH PROVIDERS IN THE EVENT THE ENTITY FAILS TO PAY SUCH CLAIMS.

F. Any bond that is secured or deposit that is posted under this section shall be released and returned:

1. To the third party intermediary entity on extinguishment by reinsurance or otherwise of substantially all liability of the insurer for the security of which the bond or deposit is held.

2. To the third party intermediary entity to the extent the bond or deposit is more than the amount required.

3. On proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator or liquidator of the third party intermediary entity or to any other properly designated official or officials who succeed to the management and control of the third party intermediary entity's assets.

G. A surety shall not terminate a bond issued pursuant to this section unless the surety files a written notice of termination with the director at least thirty days before terminating the bond.

H. A release of deposited monies shall not be made except on application to and the written order of the director. The director is not personally liable for the good faith release of all or any part of a deposit.

I. A third party intermediary entity shall approve or deny claims in the manner prescribed in chapter 20 of this title.

J. This section applies to all contracts between third party intermediary entities and health care insurers that are entered into or renewed from and after December 31, 2000.

K. For the purposes of this section:

1. "Administrator" means an entity that holds a certificate of authority pursuant to chapter 2, article 9 of this title.

2. "Covered persons" means enrollees, insureds, members, subscribers, dependents or other persons who are covered by a contract of disability insurance, subscription contract, evidence of coverage or other prepaid plan or arrangement with a health care insurer.

3. "Health care insurer" means a disability insurer, service corporation or health care services organization.

4. "Health care professional" has the same meaning prescribed in section 20-3151.

5. "Health care services organization" means an entity that holds a certificate of authority pursuant to chapter 4, article 9 of this title.

6. "Service corporation" means an entity that holds a certificate of authority pursuant to chapter 4, article 3 of this title.

7. "Third party intermediary entity" means an entity that assumes business risk through a written contract with a disability insurer, service corporation or health care services organization for the cost of providing covered health care benefits or services to a group or panel of covered persons if not all of those benefits or services will be provided by the entity or by licensed health care professionals who are subcontracted to the entity.

Section 2. Section 20-629, Arizona Revised Statutes, is amended to read:

20-629. Priority of distribution; definition

A. In a delinquency proceeding against an insurer domiciled in this state, the priority of distribution of claims from the general assets of the insurer shall be determined pursuant to this section. Every claim in each class shall be paid in full or adequate funds shall be reserved for the payment before the members of the next class may receive any payment. Subclasses may not be established within any class. The order of distribution is as follows:

1. The costs and expenses of administration incurred in connection with the delinquency proceedings AND, IN A DELINQUENCY PROCEEDING OF A HEALTH CARE SERVICES ORGANIZATION DOMICILED IN THIS STATE, CLAIMS OF PROVIDERS FOR COVERED SERVICES RENDERED PURSUANT TO SECTION 20-1069, SUBSECTION A, AFTER THE ORGANIZATION IS DECLARED INSOLVENT TO THE EXTENT THOSE CLAIMS ARE NOT FULLY FUNDED BY THE PLAN FOR THE RISK OF INSOLVENCY.

2. Claims of the Arizona property and casualty insurance guaranty fund established pursuant to section 20-662 and the life and disability insurance guaranty fund established pursuant to section 20-683 or a similar organization in another state to the extent the organization provides substantially similar protection with respect to the same kinds of insurance, including claims for unallocated loss adjustment expenses and general administrative costs and expenses.

3. Claims under insurance policies and contracts and guaranteed investment contracts except reinsurance, including claims under nonassessable policies for unearned premiums, claims under annuity contracts and, third party claims against insureds who are covered under liability insurance policies AND, IN A DELINQUENCY PROCEEDING OF A HEALTH CARE SERVICES ORGANIZATION THAT IS DOMICILED IN THIS STATE, CLAIMS OF ENROLLEES AND ENROLLEES' BENEFICIARIES INCLUDING ANY CLAIM THAT AN ENROLLEE MAY HAVE

BECAUSE THE ENROLLEE IS LIABLE TO A PROVIDER FOR SERVICES THAT ARE PROVIDED PURSUANT TO AND COVERED BY THE ENROLLEE'S HEALTH CARE PLAN WITH THE HEALTH CARE SERVICES ORGANIZATION.

4. Claims of the federal government, except those claims under paragraph 3 of this subsection and claims that are treated as secured claims.

5. Claims for compensation actually owing to employees of the insurer, other than its officers, for services rendered to the insurer. This priority is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

6. Claims of any state or local government, except those claims under paragraph 3 of this subsection and claims that are treated as secured claims.

7. IN A DELINQUENCY PROCEEDING OF A HEALTH CARE SERVICES ORGANIZATION THAT IS DOMICILED IN THIS STATE, CLAIMS OF PROVIDERS WHO ARE REQUIRED BY LAW OR AGREEMENT TO HOLD ENROLLEES HARMLESS FROM LIABILITY FOR SERVICES THAT ARE PROVIDED PURSUANT TO AND COVERED BY A HEALTH CARE PLAN.

~~7.~~ 8. Claims of other general creditors that do not fall within any other priority under this section.

~~8.~~ 9. Claims that are filed after the date specified for filing proofs of claim pursuant to section 20-640.

~~9.~~ 10. Claims of surplus note or certificate of contribution holders or other similar obligations and for premium refunds on assessable policies.

~~10.~~ 11. Claims of shareholders, members or other owners in that capacity.

B. In a delinquency proceeding against an insurer domiciled in this state, the priority of claims against the general assets of the insurer shall be determined pursuant to this section regardless of where the claimant resides or where the assets are located.

C. In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

D. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits, including without limitation assets comprising the applicable separate account, in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured are not fully discharged, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, all other persons who are entitled to priority under subsection A, paragraph 3 of this section, and also claimants against other special deposits who have received smaller percentages from their respective special deposits have been paid percentages of their claims equal to the percentage paid from the special deposit, subject to the applicable terms of any variable life contract, variable annuity contract or guaranteed investment contract that is supported by a separate account to the extent it is guaranteed by the general account. This

subsection shall not be applied in a manner that would reduce the value of any general account guaranty.

E. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender the owner's security and file the owner's claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this article or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amounts shall be conclusive. Otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

F. FOR THE PURPOSES OF THIS SECTION, "HEALTH CARE PLAN" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1051.

Sec. 3. Section 20-1069, Arizona Revised Statutes, is amended to read:

20-1069. Contingency for insolvency; plan; contents; definition

A. Each health care services organization shall have a plan for the risk of insolvency that is approved by the director and that provides for FUNDING OF all of the following:

1. Continuation of benefits for the duration of the contract period UNDER THE ENROLLEE'S HEALTH CARE PLAN or for sixty days from the date insolvency is declared, whichever is longer.

2. Continuation of benefits to ~~members~~ ENROLLEES who are confined on the date of insolvency in an inpatient facility until their discharge.

B. Entitlement to continuation of benefits under subsection A is contingent on timely payment of the premium by the enrollee or by the enrollee's representative to the health care services organization or its agent, administrator, conservator or receiver.

C. Each plan for the risk of insolvency shall include both:

1. An actuarial memorandum describing the basis on which the actuary concludes that the plan for the risk of insolvency will meet the requirements of subsection A.

2. A certification of a qualified actuary that to the best of the actuary's knowledge and judgment the rates charged will support the benefits outlined under the evidence of coverage and that the plan for the risk of insolvency satisfies the requirements of subsection A.

D. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

E. AS SOON AS PRACTICABLE AFTER COMMENCEMENT OF A DELINQUENCY PROCEEDING, THE RECEIVER SHALL SUBMIT A REPORT TO THE COURT CONCERNING THE ADEQUACY OF THE PLAN FOR THE RISK OF INSOLVENCY, INCLUDING AN ANALYSIS OF THE AMOUNT OF FUNDS AVAILABLE UNDER THE PLAN AND THE COSTS OF CONTINUATION OF

BENEFITS AS REQUIRED UNDER SUBSECTION A. THE RECEIVER SHALL UPDATE THE REPORT WITH REASONABLE FREQUENCY AS DIRECTED BY THE COURT.

F. IF AT ANY TIME THE RECEIVER DETERMINES THAT THE PLAN FOR THE RISK OF INSOLVENCY IS INADEQUATE TO PAY THE COST OF CONTINUATION OF BENEFITS AS REQUIRED UNDER SUBSECTION A, THE RECEIVER SHALL IMMEDIATELY NOTIFY THE COURT AND CONTRACT PROVIDERS.

~~E.~~ G. For purposes of this section, "continuation of benefits" includes benefits provided by ~~both affiliated and unaffiliated~~ CONTRACT PROVIDERS, NONCONTRACT providers AND EMPLOYEE PROVIDERS ON STAFF WITH THE HEALTH CARE SERVICES ORGANIZATION, subject to any authorization procedures applicable before the declaration of insolvency.

Sec. 4. Section 20-1069.01, Arizona Revised Statutes, is amended to read:

20-1069.01. Right to open enrollment period; enrollees; definitions

A. With respect to enrollees who are members of a group with more than one carrier, if there is an insolvency of a health care services organization, ~~all other carriers that participated in an open enrollment with the insolvent health care services organization at a group's last regular open enrollment period~~ EACH OPEN ENROLLMENT CARRIER shall offer enrollees of the insolvent health care services organization who are members of that group a thirty day open enrollment period beginning on the date the insolvency is declared UNLESS THE DIRECTOR DETERMINES THAT AN OPEN ENROLLMENT CARRIER LACKS SUFFICIENT HEALTH CARE DELIVERY RESOURCES TO ASSURE THAT HEALTH CARE SERVICES WILL BE AVAILABLE AND ACCESSIBLE TO ALL OF THE GROUP ENROLLEES OF THE INSOLVENT HEALTH CARE SERVICES ORGANIZATION. Each OPEN ENROLLMENT carrier shall offer these enrollees the same coverages and rates that it offered to the enrollees at the last regular open enrollment period without any waiting periods or preexisting conditions, exclusions, limitations or restrictions. On declaration of insolvency, the health care services organization shall notify each group contract holder of the insolvency. Each group contract holder shall notify its remaining OPEN ENROLLMENT carrier or carriers of the insolvency and notify its members of their right to open enrollment as provided in this section.

B. IN ADDITION TO OR INSTEAD OF THE PROCEDURE PRESCRIBED IN SUBSECTION A OF THIS SECTION, THE COURT MAY APPROVE AN ALTERNATIVE PLAN BY THE RECEIVER TO OFFER SUCCESSOR COVERAGES TO SOME OR ALL OF THE ENROLLEES OF AN INSOLVENT HEALTH CARE SERVICES ORGANIZATION IF THE COURT FINDS THAT THE ALTERNATIVE PLAN IS FAIR AND IN THE BEST INTERESTS OF THE ESTATE.

C. THE COURT MAY ORDER THAT AN OFFER OF SUCCESSOR COVERAGE PURSUANT TO SUBSECTION B OF THIS SECTION TERMINATES THE OBLIGATIONS OF AN INSOLVENT HEALTH CARE SERVICES ORGANIZATION TO AN ENROLLEE AS OF THE EFFECTIVE DATE OF THE COVERAGE THAT WOULD BE EFFECTIVE UNDER THAT OFFER IF ACCEPTED, REGARDLESS OF WHETHER THE ENROLLEE ACCEPTS THE OFFER.

~~B.~~ D. For purposes of this section: ~~,~~

1. "Carrier" means an insurer, a health care services organization, a hospital service corporation, a medical service corporation, a dental service corporation, an optometric service corporation or a hospital, medical, dental and optometric service corporation or any combination.

2. "COURT" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

3. "HEALTH CARE SERVICES ORGANIZATION" MEANS AN ORGANIZATION THAT IS LICENSED UNDER THIS ARTICLE AND A SERVICE CORPORATION THAT IS REGULATED UNDER ARTICLE 3 OF THIS CHAPTER, BUT ONLY AS TO MANAGED CARE PRODUCTS THAT THE SERVICE CORPORATION OFFERS PURSUANT TO THIS ARTICLE.

4. "OPEN ENROLLMENT CARRIER" MEANS ANY CARRIER THAT PARTICIPATED IN AN OPEN ENROLLMENT WITH THE INSOLVENT HEALTH CARE SERVICES ORGANIZATION AT A GROUP'S LAST REGULAR OPEN ENROLLMENT PERIOD.

5. "RECEIVER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

6. "SUCCESSOR", IF USED IN REFERENCE TO A HEALTH CARE SERVICES ORGANIZATION OR CARRIER, MEANS A CARRIER TO WHOM THE DIRECTOR HAS ALLOCATED A GROUP OR NONGROUP ENROLLEE THAT WAS COVERED BY THE INSOLVENT HEALTH CARE SERVICES ORGANIZATION.

Sec. 5. Section 20-1072, Arizona Revised Statutes, is amended to read:

20-1072. Nonliability of enrollees for provider or hospital charges; penalty

A. Every written contract between a health care services organization and a provider or hospital shall set forth that if the organization fails to pay for covered health care services as set forth in the enrollee's evidence of coverage or contract the enrollee is not liable to the provider or hospital for any amounts owed by the organization and the provider or hospital shall not bill or otherwise attempt to collect from the enrollee the amount owed by the organization.

B. If the written contract between the contracting provider or hospital and the organization fails to contain the required prohibition stated in subsection A, the enrollee is not liable to the contracting provider or hospital for any amounts owed by the organization.

C. No contracting provider or agent, trustee or assignee of the contracting provider or hospital may maintain an action at law against an enrollee to collect any amounts owed by the organization for which the enrollee is not liable to the contracting provider under subsection A.

D. Nothing in this section impairs the right of a provider or hospital to charge, collect from, attempt to collect from or maintain an action at law against an enrollee for any of the following:

1. Copayment or coinsurance amounts.

2. Health care services not covered by the organization, including out of area claims that are not paid by an organization on behalf of an enrollee.

3. Health care services rendered after the termination of the contract between the health care services organization and the provider or hospital, unless the health care services were rendered during confinement in an inpatient facility and the confinement began prior to the date of

termination, or unless the provider has assumed post-termination treatment obligations under the contract.

E. Nothing in this section prohibits an enrollee from seeking health care services from a contracting or noncontracting provider or hospital and accepting financial responsibility for these services.

F. No provider or hospital may charge an enrollee of a health care services organization more than the amount the provider or hospital contracted to charge the enrollee pursuant to the provider's contract or hospital's contract with the health care services organization.

G. Nothing in this section prohibits any person from informing an enrollee of either the cost of health care services performed or the status of any bill submitted to an organization in connection with health care services provided to an enrollee. Any information provided to an enrollee pursuant to this subsection shall include a statement that the information is not a bill and is for the enrollee's information only. The statement shall include the following disclosure prominently displayed at the top of the page in all capital letters: "Do not pay this statement. This is not a bill. The information provided below is for information purposes only."

H. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

I. The director shall impose a penalty against any health care provider or hospital in violation of this section of ~~not less than~~ UP TO three times the amount of the provider or hospital charges at issue.

J. The director shall investigate any complaint filed pursuant to this section and enforce the requirements of this section.

Sec. 6. Section 20-1074, Arizona Revised Statutes, is amended to read:

20-1074. Contract termination; duty to report; provision for continued services during insolvency; definitions

A. ~~On a monthly basis,~~ EACH MONTH a health care services organization shall submit to the director a list of all written provider contracts that have been terminated during the prior month. The list shall be in writing and shall include the name and address of each provider whose contract has been terminated but shall not include the reasons for termination.

B. A HEALTH CARE SERVICES ORGANIZATION SHALL INCLUDE IN ITS CONTRACTS WITH PROVIDERS A STATEMENT THAT REQUIRES THE PROVIDER TO PROVIDE SERVICES TO ENROLLEES AT THE SAME RATES AND SUBJECT TO THE SAME TERMS AND CONDITIONS ESTABLISHED IN THE CONTRACT FOR THE DURATION OF THE PERIOD AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT, UNTIL THE EARLIEST OF THE FOLLOWING:

1. THE EXPIRATION OF THE PERIOD DURING WHICH THE HEALTH CARE SERVICES ORGANIZATION IS REQUIRED TO CONTINUE BENEFITS AS DESCRIBED IN SECTION 20-1069, SUBSECTION A.

2. A NOTIFICATION FROM THE RECEIVER PURSUANT TO SECTION 20-1069, SUBSECTION F OR A DETERMINATION BY THE COURT THAT THE ORGANIZATION CANNOT

PROVIDE ADEQUATE ASSURANCE IT WILL BE ABLE TO PAY CONTRACT PROVIDERS CLAIMS FOR COVERED SERVICES THAT WERE RENDERED AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT.

3. A DETERMINATION BY THE COURT THAT THE INSOLVENT ORGANIZATION IS UNABLE TO PAY CONTRACT PROVIDERS' CLAIMS FOR COVERED SERVICES THAT WERE RENDERED AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT.

4. A DETERMINATION BY THE COURT THAT CONTINUATION OF THE CONTRACT WOULD CONSTITUTE UNDUE HARDSHIP TO THE PROVIDER.

5. A DETERMINATION BY THE COURT THAT THE HEALTH CARE SERVICES ORGANIZATION HAS SATISFIED ITS OBLIGATIONS TO ALL ENROLLEES UNDER ITS HEALTH CARE PLANS.

~~B.~~ C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

D. FOR THE PURPOSES OF THIS SECTION:

1. "COURT" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

2. "DELINQUENCY PROCEEDING" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

Sec. 7. Section 20-1379, Arizona Revised Statutes, is amended to read:

20-1379. Guaranteed availability of individual health insurance coverage; prior group coverage; definitions

A. Every health care insurer that offers individual health insurance coverage in the individual market in this state shall provide guaranteed availability of coverage to an eligible individual who desires to enroll in individual health insurance coverage and shall not:

1. Decline to offer that coverage to, or deny enrollment of, that individual.

2. Impose any preexisting condition exclusion for that coverage.

B. Every health care insurer that offers individual health insurance coverage in the individual market in this state shall offer all policy forms of health insurance coverage that are designed for, are made generally available and actively marketed to and enroll both eligible or other individuals. A health care insurer that offers only one policy form in the individual market complies with this section by offering that form to eligible individuals. A health care insurer also may comply with the requirements of this section by electing to offer at least two different policy forms to eligible individuals as provided by subsection C of this section.

C. A health care insurer shall meet the requirements prescribed in subsection B of this section if:

1. The health care insurer offers at least two different policy forms, both of which are designed for, made generally available and actively marketed to and enroll both eligible and other individuals.

2. The offer includes at least either:

(a) The policy forms with the largest and next to the largest earned premium volume of all policy forms offered by the health care insurer in this state in the individual market during a period not to exceed the preceding two calendar years.

(b) A choice of two policy forms with representative coverage, consisting of a lower level of coverage policy form and a higher level of coverage policy form, each of which includes benefits that are substantially similar to other individual health insurance coverage offered by the health care insurer in this state and each of which is covered by a method that provides for risk adjustment, risk spreading or a risk spreading mechanism among the health care insurer's policies.

D. The health care insurer's election pursuant to subsection C of this section is effective for policies offered during a period of at least two years.

E. If a health care insurer offers individual health insurance coverage in the individual market through a network plan, the health care insurer may do both of the following:

1. Limit the individuals who may be enrolled under health insurance coverage to those who live, reside or work within the service area for a network plan.

2. Within the service area of a network plan, deny health insurance coverage to individuals if the health care insurer has demonstrated, if required, to the director that both:

(a) The health care insurer will not have the capacity to deliver services adequately to additional individual enrollees because of the health care insurer's obligations to existing group contract holders and enrollees and individual enrollees.

(b) The health care insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

F. A health care insurer may deny individual health insurance coverage in the individual market to an eligible individual if the health care insurer demonstrates to the director that the health care insurer:

1. Does not have the financial reserves necessary to underwrite additional coverage.

2. Is denying coverage uniformly to all individuals in the individual market in this state pursuant to state law and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

G. If a health care insurer denies health insurance coverage in this state pursuant to subsection F of this section, the health care insurer shall not offer that coverage in the individual market in this state for one hundred eighty days after the date the coverage is denied or until the health care insurer demonstrates to the director that the health care insurer has

sufficient financial reserves to underwrite additional coverage, whichever is later.

H. An accountable health plan as defined in section 20-2301 that offers conversion policies on an individual or group basis in connection with a health benefits plan pursuant to this title is not a health care insurer that offers individual health insurance coverage solely because of the offer of a conversion policy.

I. Nothing in this section:

1. Creates additional restrictions on the amount of the premium rates that a health care insurer may charge an individual for health insurance coverage provided in the individual market.

2. Prevents a health care insurer that offers health insurance coverage in the individual market from establishing premium rates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

3. Requires a health care insurer that offers only short-term limited duration insurance limited benefit coverage or to individuals and no other coverage to individuals in the individual market to offer individual health insurance coverage in the individual market.

4. Requires a health care insurer offering health care coverage only on a group basis or through one or more bona fide associations, or both, to offer health insurance coverage in the individual market.

J. A health care insurer shall provide, without charge, a written certificate of creditable coverage as described in this section for creditable coverage occurring after June 30, 1996 if the individual:

1. Ceases to be covered under a policy offered by a health care insurer. An individual who is covered by a policy that is issued on a group basis by a health care insurer, that is terminated or not renewed at the choice of the sponsor of the group and where the replacement of the coverage is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certification prescribed in paragraph 2 of this subsection.

2. Requests certification from the health care insurer within twenty-four months after the coverage under a health insurance coverage policy offered by a health care insurer ceases.

K. The certificate of creditable coverage provided by a health care insurer is a written certification of the period of creditable coverage of the individual under the health insurance coverage offered by the health care insurer. The department may enforce and monitor the issuance and delivery of the notices and certificates by health care insurers as required by this section, section 20-1380, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996.

L. Any health care insurer, accountable health plan or other entity that issues health care coverage in this state, as applicable, shall issue and accept a certificate of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For purposes of this subdivision, eighteen months means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

7. The consumer assistance telephone number for the department.

8. The following statement in at least fourteen point type:

Important notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within 63 days to be protected by HIPAA. If you have questions, call the Arizona department of insurance.

M. A health care insurer has satisfied the certification requirement under this section if the insurer offering the health benefits plan provides the certificate of creditable coverage in accordance with this section within thirty days after the event that triggered the issuance of the certificate.

N. Periods of creditable coverage for an individual are established by the presentation of the certificate described in this section and section 20-2310. In addition to the written certificate of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, a health care insurer shall take into account all information that the insurer obtains or that is presented to the insurer on behalf of the individual.

O. A health care insurer shall calculate creditable coverage according to the following rules:

1. The health care insurer shall allow an individual credit for each day the individual was covered by creditable coverage.

2. The health care insurer shall not count a period of creditable coverage for an individual enrolled under any form of health insurance coverage if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered by any creditable coverage.

3. The health care insurer shall not include any period that an individual is in a waiting period or an affiliation period for any health coverage or is awaiting action by a health care insurer on an application for the issuance of health insurance coverage when the health care insurer determines the continuous period pursuant to paragraph 1 of this subsection.

4. The health care insurer shall not include any period that an individual is waiting for approval of an application for health care coverage, provided the individual submitted an application to the health care insurer for health care coverage within sixty-three consecutive days after the individual's most recent creditable coverage.

5. The health care insurer shall not count a period of creditable coverage with respect to enrollment of an individual, if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The health care insurer shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

6. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the health care insurer shall count a period of creditable coverage without regard to the specific benefits covered during that period.

P. An individual is an eligible individual if, on the date the individual seeks coverage pursuant to this section, the individual has an

aggregate period of creditable coverage as defined and calculated pursuant to this section of at least eighteen months and all of the following apply:

1. The most recent creditable coverage for the individual was under a plan offered by:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A governmental plan as defined in the employee retirement income security act of 1974, including a plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the United States.

(d) An accountable health plan as defined in section 20-2301.

(e) A plan made available to a person defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (f) or a dependent pursuant to section 36-2901, paragraph 4, subdivision (g) of a person eligible under section 36-2901, paragraph 4, subdivision (f), provided the person was most recently employed by a business in this state with at least two but not more than fifty full-time employees.

2. The individual is not eligible for coverage under:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(c) Part A or part B of title XVIII of the social security act.

(d) Title 36, chapter 29, except coverage to persons defined as eligible under section 36-2901, paragraph 4, subdivisions (d), (e), (f) and (g), or any other plan established under title XIX of the social security act, and the individual does not have other health insurance coverage.

3. The most recent coverage within the coverage period was not terminated based on any factor described in section 20-2309, subsection B, paragraph 1 or 2 relating to nonpayment of premiums or fraud.

4. The individual was offered and elected the option of continuation coverage under a COBRA continuation provision pursuant to the consolidated omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a similar state program.

5. The individual exhausted the continuation coverage pursuant to the consolidated omnibus budget reconciliation act of 1985.

Q. NOTWITHSTANDING SUBSECTION P OF THIS SECTION, AN INDIVIDUAL IS AN ELIGIBLE INDIVIDUAL IF:

1. THE INDIVIDUAL IS AN INDIVIDUAL ENROLLEE IN A HEALTH CARE SERVICES ORGANIZATION THAT IS DOMICILED IN THIS STATE ON THE DATE THAT THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT, INCLUDING ANY HEALTH CARE SERVICES ORGANIZATION THAT IS NOT AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.

2. THE INDIVIDUAL'S COVERAGE TERMINATES DURING THE DELINQUENCY PROCEEDING, AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED INSOLVENT.

3. THE INDIVIDUAL SATISFIES THE REQUIREMENTS OF AN ELIGIBLE INDIVIDUAL AS PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE COVERAGE.

~~Q.~~ R. Notwithstanding subsection P of this section, a newborn child, adopted child or child placed for adoption is an eligible individual if the child was timely enrolled and otherwise would have met the definition of an eligible individual as prescribed in this section other than the required period of creditable coverage and the child is not subject to any preexisting condition exclusion or limitation if the child has been continuously covered under health insurance coverage or a health benefits plan offered by an accountable health plan since birth, adoption or placement for adoption.

~~R.~~ S. If a health care insurer imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after receiving an individual's proof of creditable coverage and not later than the date by which the individual must select an insurance plan, the health care insurer shall give the individual written disclosure of the insurer's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:

1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.

2. The basis for the insurer's determination and the source and substance of any information on which the insurer has relied.

3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the insurer's determination, including an explanation of any procedures for submission and appeal.

~~S.~~ T. This section and section 20-1380 apply to all health insurance coverage that is offered, sold, issued, renewed, in effect or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

~~T.~~ U. For the purposes of this section and section 20-1380 as applicable:

1. "Affiliation period" has the same meaning prescribed in section 20-2301.

2. "Bona fide association" means, for health care coverage issued by a health care insurer, an association that meets the requirements of section 20-2324.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through 2523).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g).

(m) A policy or contract issued by a health care insurer or an accountable health plan to a member of a bona fide association.

4. "DELINQUENCY PROCEEDING" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-611.

~~4.~~ 5. "Different policy forms" means variations between policy forms offered by a health care insurer, including policy forms which have different cost sharing arrangements or different riders.

~~5.~~ 6. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

~~6.~~ 7. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, benefit insurer, health care

services organization, hospital service corporation, medical service corporation or a hospital, medical, dental and optometric service corporation.

~~7.~~ 8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health care services organization including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

~~8.~~ 9. "Higher level of coverage" means a policy form for which the actuarial value of the benefits under the health insurance coverage offered by a health care insurer is at least fifteen per cent more than the actuarial value of the health insurance coverage offered by the health care insurer as a lower level of coverage in this state but not more than one hundred twenty per cent of a policy form weighted average.

~~9.~~ 10. "Individual health insurance coverage" means health insurance coverage offered by a health care insurer to individuals in the individual market but does not include limited benefit coverage or short-term limited duration insurance. A health care insurer that offers limited benefit coverage or short-term limited duration insurance to individuals and no other coverage to individuals in the individual market is not a health care insurer that offers health insurance coverage in the individual market.

~~10.~~ 11. "Limited benefit coverage" has the same meaning prescribed in section 20-1137.

~~11.~~ 12. "Lower level of coverage" means a policy form offered by a health care insurer for which the actuarial value of the benefits under the health insurance coverage is at least eighty-five per cent but not more than one hundred per cent of the policy form weighted average.

~~12.~~ 13. "Network plan" means a health care plan provided by a health care insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers under contract with the health care insurer in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which a health care insurer may operate.

~~13.~~ 14. "Policy form weighted average" means the average actuarial value of the benefits provided by a health care insurer that issues health coverage in this state that is provided by either the health care insurer or, if the data are available, by all health care insurers that issue health coverage in this state in the individual health coverage market during the

previous calendar year, except coverage pursuant to this section, weighted by the enrollment for all coverage forms.

~~14.~~ 15. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under the health insurance policy or other contract that provides health coverage benefits. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

~~15.~~ 16. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health insurance policy or other contract that provides health coverage benefits.

~~16.~~ 17. "Short-term limited duration insurance" means health insurance coverage that is offered by a health care insurer, that remains in effect for no more than one hundred eighty-five days, that cannot be renewed or otherwise continued for more than one hundred eighty days and that is not intended or marketed as health insurance coverage subject to guaranteed issuance or guaranteed renewal provisions of the laws of this state but that is creditable coverage within the meaning of this section and section 20-2301.

Sec. 8. Retroactivity

Section 20-1072, Arizona Revised Statutes, as amended by this act, applies retroactively to from and after December 31, 2000.

Sec. 9. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR MAY 4, 2001.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 4, 2001.

Passed the House February 14, 2001,

by the following vote: 58 Ayes,

0 Nays, 2 Not Voting

Speaker of the House

Norman L. Moore

Chief Clerk of the House

Passed the Senate April 2, 2001,

by the following vote: 29 Ayes,

0 Nays, 1 Not Voting

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

_____ day of _____, 20___,

at _____ o'clock _____ M.

_____
Secretary to the Governor

Approved this _____ day of

_____, 20____,

at _____ o'clock _____ M.

_____
Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State
this _____ day of _____, 20___,

at _____ o'clock _____ M.

_____
Secretary of State

H.B. 2117

HOUSE FINAL PASSAGE
as per Joint Conference

Passed the House April 25, 2001,

by the following vote: 53 Ayes,

0 Nays, 7 Not Voting
with emergency

Jake Flake
Speaker of the House

Norman L. Moore
Pro Tempore
Chief Clerk of the House

SENATE FINAL PASSAGE
as per Joint Conference

Passed the Senate April 26, 2001,

by the following vote: 27 Ayes,

2 Nays, 1 Not Voting
with Emergency

Randal Grant
President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor

this 30 day of April, 2001,

at 11:09 o'clock A M.

Sandra Ramirez
Secretary to the Governor

Approved this 4 day of

May, 2001,

at 10:20 o'clock A M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 4 day of May, 2001,

at 4:34 o'clock P M.

Secretary of State

H.B. 2117